

Kamara Daughtry's Community Volleyball Clinic
Sunday, June 12th, 2:00 – 4:00 PM Midfield Recreation Center
Participant Registration Form

Student Information:

Name: _____ Best Contact # _____

Sex: Male / Female Current Age: _____ Current Grade _____ Birthday _____

Attends School At _____

Home Physical Address _____

Child Email _____ How many Years Playing Volleyball _____

Parent / Guardian Information:

Name: _____

Address (if different than students): _____

Best contact number _____ Email address _____

Medical Information:

Student's Physician _____ Telephone # _____

Please specify any conditions, illnesses or disabilities that might alter participation

Allergies (Food, Insect, Medications): _____

Medications (List any current medications and their purpose) _____

Chronic Physical Illnesses (Diabetes, Epilepsy, Asthma) _____

Behavioral or Emotional Conditions (ADHD, Depression, etc) _____

Physical Conditions _____

Developmental Delays or Disabilities _____

_____ initial To the best of my knowledge my child is in good physical condition to participate in this activity.

_____ initial I give permission to take photographs of my child during the activity for the purpose of being published in the newspapers or other publications.

_____ initial I give permission to administer basic first aid to my child in case of injury.

Signature Parent/Guardian _____